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MEDICARE

a reference guide for physicians

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INCLUDES 1967 CHANGES

SSI-51

AUGUST 1968

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This reference guide explains the benefits that Medicare patients are entitled to receive and tells how the program works.

Included in this guide are the important changes in hospital insurance and medical insurance protection made by the 1967 amendments to the Social Security Act. A reference on the back cover lists these changes, and this symbol (67) shows where they are explained on the page.

You may also want to pay particular attention to the new term "benefit period" which we have decided to use now instead of the words "spell of illness." This change is described on page 5.

This booklet is not a substitute for material issued to you by carriers and fiscal intermediaries who are responsible for providing you with administrative and procedural guides.

But I believe it will provide you with general information and help you and your office assistant answer questions that your Medicare patients will ask.

In addition, the people in any of the social security offices over the country are always glad to serve you or your patients in every way possible.

Robert M. Ball

ROBERT M. BALL
Commissioner of Social Security

For sale by the Superintendent of Documents, U.S. Government Printing Office
Washington, D.C. 20402 - Price 20 cents

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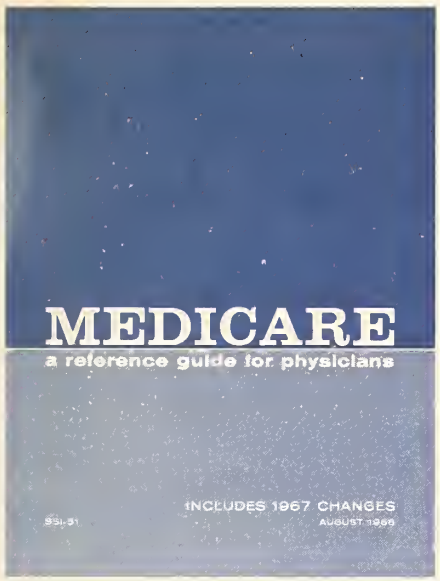
412.3
M420
1968



Like Medicare, this guide has two parts . . .

PART A--Hospital Insurance

The first section describes Part A—**hospital insurance.** Part A provides protection against the cost of hospital inpatient services, post-hospital extended care facility services, and home health agency services.

PART B--Medical Insurance

The second section describes Part B—**medical insurance.** Part B helps pay charges by physicians, outpatient hospital departments, independent laboratories, home health agencies, and for a variety of other services.

Your patient's health insurance card shows what Medicare coverage he has

Some patients have hospital insurance benefits only. Others have medical insurance benefits only, BUT MOST (about 95 percent) HAVE BOTH.

Each patient has his own health insurance card and his own claim number. The claim number always includes **a letter suffix or prefix.** In the case of a husband and wife, the numerals may be the same, but the letter will differ. The IMPORTANT thing to remember is that each patient's health insurance card shows his **own** claim number.

The patient's name and health insurance claim number must be shown on all Medicare claims exactly as they are shown on the patient's card — INCLUDING THE LETTER.

The protection your patient has is shown here. NOTE: If your patient's health insurance card shows that he has "hospital insurance benefits only," your services CANNOT be paid for by Medicare.

Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JOHN Q PUBLIC

CLAIM NUMBER
000-00-0000-A

SEX
MALE

IS ENTITLED TO
HOSPITAL INSURANCE
MEDICAL INSURANCE

EFFECTIVE DATE
7-1-66
7-1-66

Effective date(s)

SIGN HERE ◊ John J. Public

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HOW HOSPITAL INSURANCE WORKS

Hospital insurance—Part A—helps pay for services provided by health facilities that participate in Medicare.

The three broad areas of coverage are:

- **HOSPITAL INPATIENT SERVICES**

And . . . post-hospital services from—

- **EXTENDED CARE FACILITIES**

and / or

- **HOME HEALTH AGENCIES**

COVERED SERVICES

The services Medicare helps pay for are called *"covered services."* Part A covers almost all the services ordinarily furnished to inpatients by participating hospitals and extended care facilities or by home health agencies to patients confined to their home or other place of residence. (In some cases, Part A can even help pay for care in certain hospitals that do not participate. See page 14.)

BENEFIT PERIOD

Use of Part A covered services is limited within *"benefit periods."* A benefit period is a period of time for measuring use of covered services. (In the first *Physician's Reference Guide* and in other Medicare publications, this period of time was called a "spell of illness." The law uses this term. But so many people thought the term referred to a single illness or particular "spell" of sickness that it is now called a "benefit period.")

The first time a patient receives Part A covered services—after his hospital insurance starts—begins his first benefit period. This benefit period *ends* as soon as he has not been an inpatient of ANY hospital (or facility that mainly provides skilled nursing care) *for 60 days in a row*. After the 60 days, a new benefit period can start the next time your patient needs to go into a hospital. And *this* benefit period ends as soon as he has not been an inpatient of ANY hospital (or facility that mainly provides skilled nursing care) *for 60 days in a row*.

NOTE: There is *no limit* to the *number* of benefit periods your patient may have. But another benefit period can start only after he has NOT been an inpatient of ANY hospital (or facility that mainly provides skilled nursing care) for *60 days in a row*.

How the Use of Hospital Insurance Benefits Is Counted

WHEN a beneficiary is a hospital inpatient

PART A BENEFITS COVER:

Up to 90 "hospital days" in *each* benefit period. (May be extended by "lifetime reserve" days. See page 7.)

WHEN he is admitted to an extended care facility

PART A BENEFITS COVER:

Up to 100 "extended care facility" days in *each* benefit period.

WHEN a physician establishes a plan of care to be provided by a home health agency

PART A BENEFITS COVER:

Up to 100 "home health visits" for *each* benefit period. (See page 13 for the 1-year time limit on home health visits.)

These three kinds of benefits are described in detail on the following pages.

HEALTH FACILITIES MUST MEET CERTAIN CONDITIONS TO TAKE PART IN MEDICARE

To participate in the Medicare program, health facilities must meet standards which help assure that they will be able to provide high quality health care. In addition, they must not charge the Medicare beneficiary for services paid for by the program, and they must abide by title VI of the Civil Rights Act, which prohibits discrimination based on race, color, or national origin.

A Personal Record of Benefits Used

The patient does not have to keep track of how many "days" or "visits" he uses in a benefit period. A record is kept for him by the Social Security Administration.

After your patient has had services covered by Part A, he will receive a notice that shows his use of benefits and how many "days" or "visits" he has left in *this* benefit period. The facility is also advised, when it sends in an admission or start of care notice, how many "days" or "visits" the patient is eligible for in his current benefit period.

Most people will never use all their "days" or "visits" because they rarely exhaust available benefits. If they have been out of a hospital (or other facility that mainly provides skilled nursing care) for 60 days in a row, a new benefit period begins the next time a patient is admitted to a hospital.

EXAMPLE:

Mr. L was in the hospital for 2 weeks and then went home.

After being at home for 80 days, Mr. L needs to return to the hospital. When Mr. L is admitted this time, he is in a new benefit period. That means he is again eligible for up to 90 hospital days because more than 60 days have gone by since he was last in a hospital (or other facility that mainly provides skilled nursing care). The benefit days Mr. L used the time before do not matter because he is in a new benefit period.

However, because Mr. L had been in the hospital only 14 days, he still had 76 hospital benefit days left in the original benefit period. If he had had to go back to the hospital within 60 days, instead of 80, he could have used any of these remaining days that he needed during this second stay.

"Lifetime Reserve" of 60 Additional Hospital Days

'67 The "lifetime reserve" provides extra hospital benefit days if the patient needs them. He can use them if he needs more than 90 days of hospital care in the same benefit period.

Each "lifetime reserve" day used permanently reduces the total remaining.

The patient will usually want to use "lifetime reserve" days if he needs hospital care after he has used all his 90 days in a benefit period. Unless he decides not to use them, the extra days of hospital care will be automatically taken from the "lifetime reserve" of 60 additional days.

If the patient decides not to use his "lifetime reserve" days, his decision must be in writing. The patient may ask for your advice before making a decision in this matter.

EXAMPLE:

Mrs. S had to go to the hospital a number of times in the same benefit period and used up all her 90 days. If Mrs. S has to go back to the hospital before a new benefit period starts, she can draw on her "lifetime reserve" days to help pay for the additional hospital care.

Patient Responsibility Under Hospital Insurance

IN EACH BENEFIT PERIOD

THE PART A DEDUCTIBLE

Part A of Medicare covers a broad range of services. However, Part A does not pay all hospital charges in a benefit period.

In *each* benefit period, the patient is responsible for the *first* $40 in covered hospital inpatient charges. The patient is responsible for this deductible only ONE TIME in the *same* benefit period regardless of how many times he is admitted.

The hospital inpatient deductible was set by Congress to be $40 through December 31, 1968. The law requires a yearly review, prior to each October 1, beginning in 1968, to determine the Part A deductible for the next calendar year. The deductible may be adjusted annually to reflect changes in average hospital per diem costs. Estimates indicate it may be $44 for 1969 (and the co-insurance under Part A — a percentage of the deductible — would also be adjusted).

NOTE: An explanation of the Part A deductible for whole blood (or units of packed red blood cells) is found on page 27.

THE PART A CO-INSURANCE

In *each* benefit period, after a patient has used 60 of his 90 hospital inpatient days, he is responsible for one-fourth of the Part A deductible ($10) for each day of additional care he may need from the 61st through the 90th day in *this* benefit period.

After using all 90 hospital inpatient days in a single benefit period, a patient may elect to draw on his 60-day "lifetime reserve." When he uses "lifetime reserve" days, he is responsible for one-half of the Part A deductible ($20) for each day of "lifetime reserve" used.

And in *each* benefit period, when an eligible patient has *used 20 of his 100 extended care facility days,* he is responsible for one-eighth of the Part A deductible ($5) for each day of additional care he uses from the 21st through the 100th day in *this* benefit period.

There are NO patient financial responsibilities for home health services covered under Part A.

PATIENT RESPONSIBILITY MET UNDER PART B CANNOT BE USED TO MEET PATIENT RESPONSIBILITY UNDER PART A.

Benefits for Inpatient Care in A Participating Hospital

The chart below shows some of the services that hospital insurance will help pay for and some that it cannot pay for.

Part A Helps Pay For:	Semiprivate room (2-4 beds) and all meals, including special diets.
	Operating room charges.
	Regular nursing services (including intensive care nursing).
	Drugs furnished by the hospital.
	Laboratory tests.
	X-ray and other radiology services.
	Medical supplies such as splints and casts.
	Use of appliances and equipment furnished by the hospital.
	Medical social services.
Part A Does NOT Pay For:	Physician services.
	Personal comfort or convenience items.
	Private duty nurses.
	Any extra charge for use of a private room, unless ordered for medical reasons.
	Noncovered levels of care. (See page 12.)

Special Rules for Benefits in Psychiatric Hospitals

'67 For care in a psychiatric hospital, there is a lifetime limit of 190 hospital benefit days.

If a patient is in a *psychiatric hospital* on the date his hospital insurance starts, the days in the psychiatric hospital during the 150-day period just before this date count against the total number of benefit days he can use in his first benefit period in a psychiatric hospital or in a general hospital for diagnosis or treatment of mental illness.

However, in such a situation if the patient is transferred to a non-psychiatric hospital after his coverage starts for treatment of a condition other than mental illness, he **will** be eligible for benefits for such care.

Days spent as an inpatient of a psychiatric hospital when no benefit payment can be made —or days in any other hospital whether or not benefit payments are made—are *not* counted toward the 190-day lifetime limit for benefit days in psychiatric hospitals.

Extended Care Benefits After the Patient Leaves the Hospital

Sometimes a patient who no longer needs the intensive care of a hospital still requires full-time skilled nursing care and other health services that cannot be furnished in his home. Hospital insurance provides coverage when your patient is transferred from the hospital to a participating extended care facility if:

1. Extended care services are medically necessary;
2. The patient has been an inpatient of a participating hospital (or a hospital that meets the emergency hospital conditions—see page 14) for at least 3 consecutive days;
3. Admission is within 14 days after discharge from the hospital;
4. Admission is for further treatment of a condition for which the patient was treated in the hospital; and
5. The primary purpose of the care is to meet the patient's need for skilled nursing and other professional services (see page 12).

NOTE: When a patient is discharged from an extended care facility but readmitted (or admitted to another) within 14 days, he need not have a new 3-day hospital stay. He can still be eligible for any remaining extended care facility days in this benefit period.

The chart below shows some of the services that hospital insurance will help pay for and some that it cannot pay for.

Part A Helps Pay For:	Semiprivate room (2-4 beds) and all meals, including special diets.
	Regular nursing services.
	Drugs furnished by the extended care facility.
	Physical, occupational, and speech therapy.
	Medical supplies such as splints and casts.
	Use of appliances and equipment furnished by the facility.
	Medical social services.
Part A Does NOT Pay For:	Physician services.
	Personal comfort or convenience items.
	Private duty nurses.
	Any extra charge for use of a private room, unless ordered for medical reasons.
	Noncovered levels of care. (See page 12.)

Utilization Review

Hospitals and extended care facilities are required, as a condition of participation, to establish a utilization review plan applicable to all Medicare patients in the institution. These plans may vary, within broad guidelines, from institution to institution.

The purpose of utilization review is to serve as an additional mechanism of professional review and evaluation which will contribute to the more effective use of institutional services. Each utilization review committee must include at least two physicians in its membership.

The utilization review committee has two basic roles. The first is essentially educational. This involves a review, on a random sample or other basis, of admissions, duration of stays, and professional services furnished.

The second function involves the review of all long-stay cases. The purpose of this function is to periodically confirm the patient's need for continuation of the level of care he is receiving. *Alternative* levels of care are an integral part of these considerations. Thus, the committee may determine that care in another health facility, his home, or other place of residence would be the appropriate level of care for a specific patient.

If, after consultation with the attending physician, review of a particular case indicates that the patient no longer needs the level of care being furnished, notice of this determination must be given to the facility, the attending physician, and the patient within 48 hours. Obviously, in such a case Medicare does not require the patient's discharge. But, no further payment can be made after 3 days following the notice. Of course, under Medicare when a benefit payment is not allowed, the patient has a right of appeal or review.

Noncovered Levels of Care

In the first *Physician's Reference Guide,* and in other Medicare publications, it was explained that "custodial care" is excluded from coverage. The term "noncovered care" is now used to apply to all levels of care (including custodial care and intermediate care) which are not covered by Medicare as inpatient hospital services, extended care services, or home health services.

The question of noncovered care most often arises when a patient is in an extended care facility. Sometimes the issue arises upon admission, but often it presents itself after the patient has been in the facility for some time and his treatment needs have changed.

Care is Covered:

- If a patient in an extended care facility is admitted for further treatment of a condition for which he received inpatient hospital care;
- If he is receiving skilled health services which are essential to his proper medical care; and
- If the need for these skilled services is the primary purpose of his inpatient stay in the facility.

When this level of care is required, payment can be made if the patient is otherwise eligible for Medicare benefits.

The attending physician's patient-care orders are important evidence as to the level of care his patient needs. Information from the hospital from which the patient was transferred is an important additional source of data.

Of course, the periodic review of long-stay cases—including review of the patient's medical record—by the facility's utilization review committee is essential to verify the level of care needed by the patient during an extended stay.

Home Health Benefits After Hospital Discharge

When a patient has had covered inpatient services in a hospital or extended care facility, his physician may want him to have continued care from a participating home health agency at his home or other place of residence. Home health agencies may furnish a variety of covered services including part-time nursing; physical, occupational, and speech therapy; and the part-time services of home health aides.

Part A pays for all covered services—for up to 100 visits—furnished by the participating home health agency **during the 12-month period following the patient's most recent discharge from a hospital or extended care facility** in which he received covered services if:

1. He was an inpatient of a participating hospital (or otherwise qualified hospital—see page 14) for at least 3 consecutive days;
2. He is confined to his home or other place of residence;
3. A plan of care is established and periodically reviewed by a physician. To qualify, the plan must be established *within 14 days of the discharge* from the hospital or extended care facility where the patient received covered services; and
4. The care provided by the home health agency is for further treatment of a condition for which the patient was treated while an inpatient of the hospital or extended care facility and the visits are medically necessary.

NOTE: Services of home health agencies are covered by both hospital and medical insurance. When a patient is confined to his home but is not eligible for Part A home health coverage for any reason, he may be eligible for coverage or a continuation of coverage under Part B. (See page 20.)

HOW HOME HEALTH AGENCY "VISITS" ARE COUNTED

One "visit" is counted **each** time the patient receives a covered health care service from a home health agency. Two **different** services on the same day (for example, a call by a nurse and a physical therapist) would be two visits, or two distinct calls for the **same** service would be two visits.

The chart below shows some of the services that hospital insurance will help pay for and some that it cannot pay for.

Part A Helps Pay For:	Part-time nursing care.
	Physical, occupational, or speech therapy.
	Part-time services of home health aides.
	Medical social services.
	Medical supplies furnished by the agency.
	Use of medical appliances.
Part A Does NOT Pay For:	Physician services.
	Full-time nursing care.
	Drugs and biologicals.
	Personal comfort or convenience items.
	Noncovered levels of care. (See page 12.)
	Meals delivered to the home.

Benefits for Inpatient Care in Non-Participating Hospitals

'67 Medicare, as a general rule, pays only for services provided by hospitals that elect to participate and meet certain specified "conditions of participation."

Nearly all hospitals in the country do participate. But, when a patient has to be admitted to a hospital that does not take part in Medicare, his hospital insurance—Part A—may be able to pay some of the hospital charges.

Emergency Admissions

Part A benefit payments to hospitals that do not participate can be made only for EMERGENCY ADMISSIONS.

Emergency services under Medicare are defined as those services that are necessary to prevent death or serious impairment to the health of the individual and which, because of the threat to the life or health of the individual, necessitate the use of the most accessible hospital available that is equipped to furnish such services.

Benefit payments for **emergency admissions** to a non-participating hospital can be made if the following conditions exist:

1. The hospital is licensed;
2. All care is under the supervision of a physician; and
3. The hospital provides full-time nursing care.

Determination of When Care is Emergency

Considerable emphasis as to whether payment can be made under this provision for **emergency admissions** is placed on the statement of the attending physician. However, final responsibility as to the determination rests, after proper medical consultation, with the Social Security Administration.

Benefit payments for emergency care can be made for only that period of time during which the emergency continues.

Payment Procedures for Emergency Care

Usually, the hospital bills the program for benefits, even though it is not participating in Medicare. But, each non-participating hospital elects, annually, whether to bill the program or to charge its patients.

If the hospital bills the program, the payment for the services covered is the same as if the patient were admitted to a participating hospital.

If, as sometimes happens, a non-participating hospital elects to bill the patient for an emergency admission, then the patient can file a claim for benefit payment.

When the patient files a claim for payment, after applying the usual Part A responsibilities (inpatient deductible, blood deductible, and co-insurance — if any), the benefit payment, *made directly to the patient,* will be:

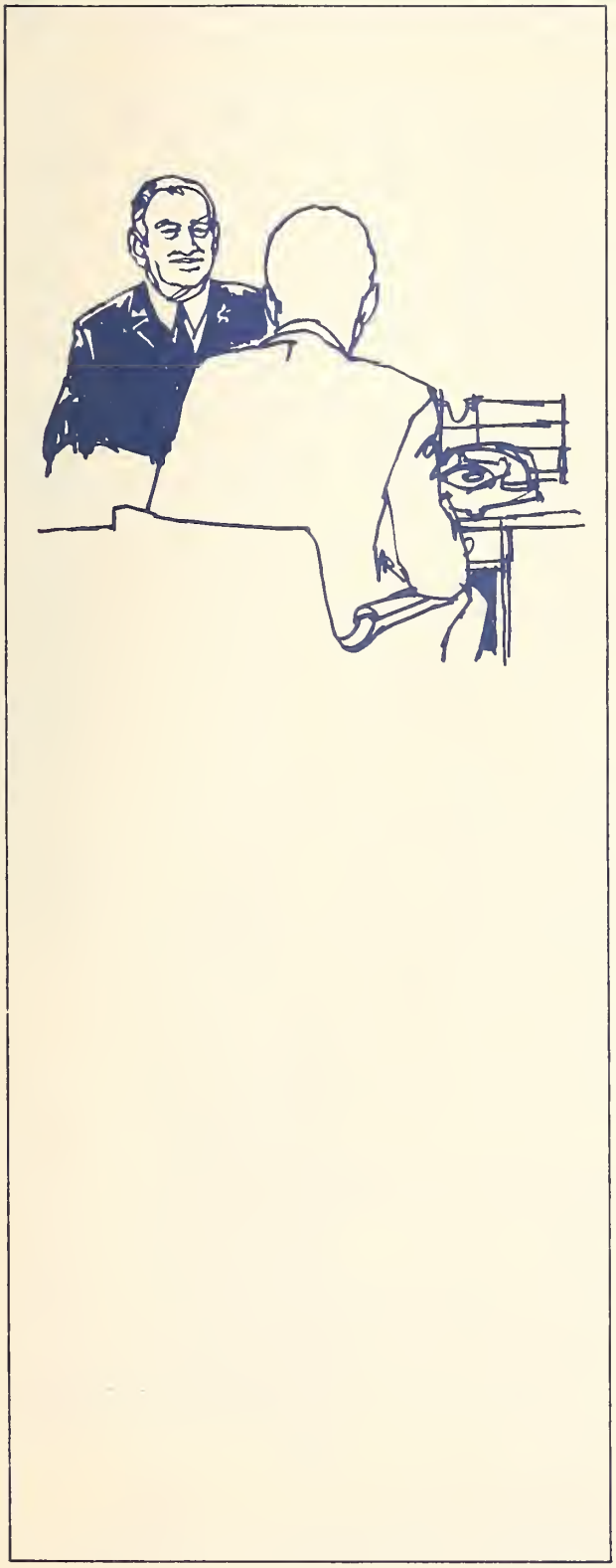
- 60 percent of the reasonable charge for routine services in semiprivate room; and
- 80 percent of the reasonable charge for ancillary services.

If the hospital bills the patient, he can make a claim for this payment at any social security office.

A Special Provision Now Makes Some Benefits Payable for Certain Hospital Admissions Before January 1, 1968.

If, for any reason, a patient with Medicare coverage was admitted to a hospital **before** January 1, 1968, but **could not** get benefits because the hospital did not participate in Medicare, he should get in touch with a social security office promptly. Some benefits may now be payable if a claim is made by December 31, 1968.

HOW MEDICAL INSURANCE WORKS



Medical Insurance (Part B) helps pay for:

- **PHYSICIAN SERVICES**
- **HOSPITAL OUTPATIENT SERVICES**
- **HOME HEALTH SERVICES**
- **OUTPATIENT PHYSICAL THERAPY**
- **MEDICAL SERVICES AND SUPPLIES**

. . . and certain other health care services

Part B benefit payments are usually made on the basis of a **reasonable charge.** However, payments made to participating institutions, agencies, and some group practice prepayment plans are on the basis of reasonable cost.

The determination of a **reasonable charge** takes into consideration ". . . the customary charge for similar services generally made by the physician or other person furnishing such services, as well as the prevailing charges in the locality for similar services."

The carrier for the area in which the covered services are furnished receives the claims and is responsible for making reasonable charge determinations, for making payments, and for conducting reviews and hearings when such payments are disputed.

Patient Responsibility Under Medical Insurance

THE PART B $50 DEDUCTIBLE

Under Part B, no benefit payment can be made for the first $50 in reasonable charges for covered services **in each calendar year.**

This $50 annual deductible can be met by a single expense **or** by an accumulation of expenses for various Part B covered services. It has to be met only **one time** in each year.

There is a special rule for incurred expenses that are used to count toward the $50 annual deductible in the last 3 months of each year. (See page 25.)

NOTE: An explanation of the Part B deductible for whole blood (or units of packed red blood cells) is found on page 27.

THE PART B CO-INSURANCE

In each calendar year, after the $50 annual deductible is met and these bills have been sent to the carrier, Part B pays 80 percent of the reasonable charges for all additional Part B covered services. The patient is responsible for the balance.

There are two exceptions to the usual Part B benefit payments:

- There is a maximum payment limit of $250 for *outpatient* psychiatric services by a physician in each calendar year.
- Part B pays 100 percent of the reasonable charge of physicians who perform radiology or pathology services for inpatients of participating (or otherwise qualified) hospitals. (See page 18.)

PATIENT RESPONSIBILITY MET UNDER PART A CANNOT BE USED TO MEET PATIENT RESPONSIBILITY UNDER PART B.

Physician Services

Medical insurance will help pay for all covered physician services.

After the $50 annual deductible, Part B pays 80 percent of the reasonable charges for covered services.

The medical insurance payment is made directly to the physician when both he and his patient agree to assignment. (See page 22.)

The payment is made to the patient when there is no assignment. (See page 23.)

The chart below shows some of the services that medical insurance will help pay for and some of the services that it cannot pay for.

Part B Helps Pay For:

- Medical and surgical services by a doctor of medicine or osteopathy. (Part B cannot make payment for services performed outside the United States.)
- Certain medical and surgical services by a doctor of dental medicine or a doctor of dental surgery.
- Certain services by a podiatrist within the limits authorized by the State in which he practices. '67
- Other services which are ordinarily furnished *in the physician's office* and included in his bill. These include:
  - Diagnostic tests and procedures
  - Medical supplies
  - Services of his office nurse
  - Drugs and biologicals which cannot be self-administered

Part B Does NOT Pay For:

- Routine physical checkups.
- Routine foot care, treatment of flat feet, and subluxations of the feet. '67
- Eye refractions and examinations for prescribing, fitting, or changing eyeglasses. '67
- Hearing examinations for prescribing, fitting, or changing hearing aids.
- Immunization (unless directly related to an injury or immediate risk of infection such as an anti-tetanus shot given after an injury).
- Drugs and biologicals which *can* be self-administered.
- Services of certain practitioners; for example:
  Christian Science practitioners, Chiropractors, and Naturopaths.

Dental Services

Medical insurance covers the services of dentists only when the services involve surgery of the jaw or related structures or setting of fractures of the jaw or facial bones.

Medical insurance does *not* pay for dental services such as the care, filling, removal, or replacement of teeth, or treatment of the gum areas nor for surgery or other services related to these kinds of dental care. However, if the physician decides that the medical condition requires the patient's hospitalization, Part A can help pay for the hospital services even though the dental care is not covered.

Radiology and Pathology Services Furnished to Hospital Inpatients

(67) As of April 1, 1968, medical insurance pays the full reasonable charges of physicians performing radiology and pathology services for hospital inpatients if the hospital is participating (or meets basic conditions of participation).

Since the benefit payment for radiology and pathology services furnished by physicians to inpatients of participating hospitals is 100 percent of the reasonable charge, no part of the charges for these services can be applied to the $50 annual deductible.

The physician may have an arrangement with the hospital to bill his patients. If not, he may accept assignment or bill directly.

Ambulance Services

Medical insurance will help pay for ambulance transportation to a hospital or skilled nursing home only when (1) ambulance services are medically necessary to protect the health of the patient, (2) transportation by other means could endanger the patient's health, and (3) the patient is taken to the *nearest* institution that is equipped to take care of him (or to one in the same locality).

Under similar restrictions, medical insurance can help pay for ambulance services from one hospital to another, from a hospital to a skilled nursing home or from a hospital or skilled nursing home to the patient's home if his home is in the same locality as the hospital or skilled nursing home.

Hospital Outpatient Benefits

'67 As of April 1, 1968, all covered hospital outpatient services are paid for by medical insurance only.

After the $50 annual deductible, Part B pays 80 percent of the remaining reasonable charges for covered hospital outpatient services.

In determining what to collect from the patient, the hospital is required to take into account the patient's deductible status shown on his most recent explanation of benefits form. (See page 24.)

The hospital will, except in unusual circumstances, prepare the Medicare claim for outpatient services. This claim may also include the charges for services of hospital-based physicians.

When the hospital does not bill for a physician, he may handle the claim in his usual way—either by assignment or itemized bill.

The chart below shows some of the services that medical insurance will help pay for and some of the services that it cannot pay for.

Part B Helps Pay For:	Laboratory and other diagnostic services.
	X-ray and other radiology services.
	Emergency room services.
	Medical supplies.
Part B Does NOT Pay For:	Tests given as part of a routine checkup.
	Eye refractions and examinations for prescribing, fitting, or changing eyeglasses.
	Immunizations (unless directly related to an injury or immediate risk of infection such as an anti-tetanus shot given after an injury).
	Hearing examinations for prescribing, fitting, or changing hearing aids.

Outpatient Physical Therapy Services

'67 Physical therapy services are covered by medical insurance when they are furnished under the direct supervision of a physician or when they are furnished as part of covered home health services.

Starting July 1, 1968, outpatient physical therapy services can also be covered when furnished by participating institutions, home health agencies, and approved clinics, rehabilitation agencies, or public health agencies when the services are furnished under a plan established and periodically reviewed by a physician.

Emergency Outpatient Care at Non-Participating Hospitals

'67 If the patient receives emergency outpatient care from a non-participating hospital which meets certain conditions (see page 14), the Medicare payment will ordinarily be made to the hospital. Hospitals may bill the patient for any unmet part of the $50 annual deductible plus 20 percent of the remaining reasonable charges.

Some of these hospitals may choose to bill the patient instead of Medicare. In such a case, Part B will pay the patient 80 percent of the remaining reasonable charges after the $50 annual deductible. The patient may get in touch with any social security office for help in making the claim.

Home Health Benefits

These are the same types of home health benefits provided under hospital insurance. They include part-time nursing services and services by physical, occupational, and speech therapists, as well as the part-time services of home health aides. Under Part B there is no prior hospitalization requirement.

After the $50 annual deductible, Part B pays 80 percent of the remaining reasonable cost.

Medical insurance will help pay for up to 100 medically necessary home health visits each calendar year if the following conditions are met:

- The patient is confined to his home or other place of residence; and
- A physician establishes and periodically reviews the home health care plan.

NOTE: When the patient is eligible under both parts of Medicare, Part A home health visits are counted first. Then, if the patient uses all 100 visits under Part A, he can continue coverage of home health visits under Part B.

The chart below shows some of the services that medical insurance will help pay for and some of the services that it cannot pay for.

Part B Helps Pay For:	Part-time nursing care.
	Physical, occupational, and speech therapy.
	Part-time services of home health aides.
	Medical social services.
	Medical supplies furnished by the agency.
	Use of medical appliances.
Part B Does NOT Pay For:	Full-time nursing care.
	Drugs and biologicals.
	Personal comfort or convenience items.
	Noncovered levels of care (see page 12).
	Meals delivered to the patient's home.

Other Medical Services and Supplies

Medical insurance helps pay for a number of different services and supplies necessary in the treatment of an illness or injury. These services may be covered when furnished by a physician as part of his treatment or by a medical clinic in connection with the treatment.

When a participating hospital, extended care facility, or home health agency provides covered services and supplies, it makes the claim for Medicare payment and bills the patient for any unmet part of the $50 annual deductible plus 20 percent of the remaining reasonable charges.

When services or equipment are furnished by a supplier, the claim may be made by the supplier, or by the patient. **A physician's order for the equipment should be sent with the claim.** After the $50 annual deductible, medical insurance pays 80 percent of the remaining reasonable charges.

The chart below shows the kinds of medical services and supplies medical insurance can help pay for when they are medically necessary and ordered by the physician and some that it cannot pay for.

Part B Helps Pay For:	Diagnostic procedures, such as laboratory tests and X-ray services, furnished by participating facilities or approved independent laboratories.*
	Radiation therapy.*
	Surgical dressings, splints, casts, and similar devices.*
	Devices (other than dental) to replace all or part of an internal body organ. This includes corrective lenses after a cataract operation.*
	Rental or purchase of durable medical equipment prescribed by a physician to be used in the patient's home. '67
	Certain ambulance services.
	Certain portable diagnostic X-ray services. '67
	Drugs and biologicals which cannot be self-administered.
Part B Does NOT Pay For:	Drugs and biologicals which *can* be self-administered.
	Hearings aids.
	Eyeglasses.
	False teeth.
	Orthopedic shoes or other supportive devices for the feet—except when shoes are a part of leg braces.

*If a patient is in a hospital or extended care facility and, for some reason hospital insurance cannot pay for these services (for example, because he has used up his benefit days) medical insurance can help pay for them. '67

How to Claim Medical Insurance Benefits

PAYMENT TO THE PHYSICIAN OR SUPPLIER

If the physician (or supplier) and his patient both agree to assignment, the medical insurance payment **is made to the physician (or supplier).**

A. The patient completes and signs Part I of the *Request for Medicare Payment* (SSA–1490). A sample copy of this form is on page 28. (The physician's (supplier's) office assistant may want to help the patient complete Part I.)

B. The physician (supplier) completes Part II of the form, and

C. He sends the *Request for Medicare Payment* form to the carrier in his area.

Under the law, **when there is agreement to assignment, the payment is made to the physician (supplier).** When the payment is to be made directly to the physician (supplier) on assignment, the law requires that the reasonable charge, as determined by the carrier, will be the total charge. And the patient is responsible for only any unmet part of the $50 annual deductible and 20 percent of the remaining reasonable charges.

How to Claim Medical Insurance Benefits

PAYMENT TO THE PATIENT

When either the physician (or supplier) or the patient do not agree to an assignment of the medical insurance payment, it is made **to the patient.** (The patient can make his claim with an itemized bill, paid or not paid.) 67

A. The patient completes and signs Part I of the *Request for Medicare Payment*. (The physician's (supplier's) office assistant may want to help the patient complete Part I.)

B. The physician (supplier) may either:
Complete Part II of the *Request for Medicare Payment*, or
Give the patient an itemized bill.
The itemized bill should show the same information that would be furnished if Part II were completed: the date, place, description of each service, and the charge for each service.

C. The patient (or physician) sends the *Request for Medicare Payment* to the carrier for the area. If Part II has not been completed by the physician, the itemized bills should be attached and the patient's name and claim number should be on each bill.

(The AMA's House of Delegates, at the 1967 Clinical Convention, formally recognized the physician's responsibility when he chooses to use the direct billing method for "reporting fully and specifically in his billing the nature of the services provided so that the patient may be properly reimbursed by the carrier. . . .")

When to Submit Medical Insurance Claims

Medical insurance does not pay any of the first $50 of covered medical expenses a patient has each year. So, patients often hold their small bills until these total $50 or more.

There may be times, however, when your patient should send in his smaller bills before they amount to $50. The carrier will credit charges toward the deductible in the order in which they are received, not by the order in which the services were performed.

If, for example, the patient had already accumulated medical bills totaling $48 when he receives your services and you both agree to an assignment, the only way the Medicare payment could be made to you without applying the total deductible is if the patient sends in his prior bills so that these can be applied against his $50 annual deductible **before** your claim is sent in.

Time Limits for Submitting Claims

'67 Under the law, there are time limits for making payment on claims. These limits are as follows:

WHEN SERVICES WERE RECEIVED	WHEN CLAIMS MUST BE FILED
October 1, 1966—September 30, 1967	By December 31, 1968
October 1, 1967—September 30, 1968	By December 31, 1969
October 1, 1968—September 30, 1969	By December 31, 1970

NOTE: For services received between July 1, 1966, and September 30, 1966, the time limit for sending in claims ended on April 1, 1968.

Explanation of Benefits

The patient always receives a statement that shows his use of Part B benefits. The statement shows the amount of payment and/or any amount that has been credited toward his $50 annual deductible. No statement is sent to the physician when payment is made directly to the patient.

The New "Request for Medicare Payment" Form

Page 28 shows the new *Request for Medicare Payment* form. Instructions for completion of the form are shown on page 29. The older claims form may still be used, but supplies of the new form are available from the carrier serving your area.

The Carry-Over Rule

To help your patient who might otherwise have to meet the $50 annual deductible twice in a short period, the law provides a special "carry-over" rule for Part B. This rule permits the same expenses credited toward the $50 annual deductible during October, November, or December of any year to be credited **again** toward the deductible for the next year.

If FOR THE YEAR expenses for covered services are $50 or less, then any expenses for covered services that your patient has **in October, November,** or **December** of that year can count toward the $50 annual deductible for the **next** year.

If FOR THE YEAR expenses for covered services do not exceed $50 UNTIL the last 3 months of the year, then any covered expenses in the last 3 months which counted toward the $50 annual deductible for that year can be counted AGAIN toward the deductible for the next year.

Thus, it is possible for your patient to have already met all or part of the $50 annual deductible even before he receives treatment or services in the new year.

Answers to Questions Often Asked

1. **Who makes the decision whether to rent or purchase durable medical equipment which I prescribe for use in my patient's home?**

   Your patient. But there are several points he will need to keep in mind if he decides to purchase: (1) for expensive equipment, the Part B payments are made over a period of time and are based on a reasonable rental rate; and (2) these payments stop when the need for the medical equipment ends. In this case, your patient may have to bear any remaining cost of the equipment after the medical need has ended.

   Therefore, in deciding whether to buy or rent, your patient may need your advice regarding the approximate length of time the equipment will be needed.

2. **Although Medicare cannot pay for some levels of care provided by extended care facilities, patients receiving a noncovered level of care may still need the services of a physician. May I still receive payment for services I render my patients who are receiving a noncovered level of care in such an institution?**

   Yes. Part B pays for physicians' services wherever they are furnished in the United States.

3. **What happens if a patient wants to assign the medical insurance payment and the physician does not want to accept assignment?**

   The physician does not have to accept assignment. If the physician does not agree to take assignment, the payment will be made directly to the patient when he submits a claim with an itemized bill, whether or not it has been paid.

4. **If a physician does accept assignment, does he establish a precedent for his office that must be followed in the future?**

   No. The physician (supplier) decides each situation separately. The fact that he does accept assignment from a patient on one occasion does not obligate the physician to continue that arrangement—even with the same patient. The matter of payment for the physician's services is one that is strictly between the physician and his patient.

Answers to Questions Often Asked (continued)

5. How are Part B claims settled on behalf of deceased persons?

If the beneficiary paid the bill before his death, the Medicare payment becomes part of the estate and is made in the order of priority established by State law.

If a bill for covered services has been paid by someone other than the beneficiary, the Part B payment is made to the person who paid it.

If the bill has not been paid, the Part B payment may be made to the physician or supplier on assignment. This may be done ". . . *only if the person or persons who provided the service agrees that the reasonable charge is the full charge for the service.*"

For assistance, get in touch with the nearest social security office.

6. How do people qualify for Medicare?

There are separate rules for each part of Medicare:

To qualify under Part A:

Hospital insurance is automatic for almost everyone 65 or over before 1968 and everyone 65 or over who is entitled to social security or railroad retirement benefits whether or not the person actually receives monthly cash benefits.

People who reach 65 between 1967 and 1975 *may* be entitled to hospital insurance even though they are not eligible for cash benefits if they have enough work credits under social security. Patients should be encouraged to get in touch with the social security office about hospital insurance even though they do not expect to receive cash benefits. If the patient is otherwise eligible, Part A claim payments can be made retroactively for up to one year.

To qualify under Part B:

Medical insurance is available to nearly everyone 65 or older who signs up for it and pays the premiums. There are certain times to sign up.

A person's first chance to sign up is in the 3-month period just before the month in which he reaches 65. When a person enrolls during these 3 months, his Part B coverage is effective on the first day of the month in which he becomes 65. He can sign up in the month he is 65 or any time during the next 3 months. Delayed enrollment means a delay in the starting date of Part B coverage.

When a person fails to enroll during the 7 months—his first chance—he can sign up during an "open season" (the first 3 months of each year). He may have to pay a higher premium for late enrollment, and if he waits more than 3 years after his first opportunity to sign up, he will no longer be eligible.

Part B coverage is *not* retroactive. Claims cannot be paid for services rendered before the effective date shown on your patient's health insurance card.

7. If a patient is unable to pay any or all he owes toward the $50 annual deductible, can a Part B payment be made?

Part B payments can be made for 80 percent of the reasonable charge for covered services after the patient has *incurred* $50 in expenses. When there is an assignment, payment is made to the physician. If the physician and the patient do not agree to assignment, payment is made to the patient.

Regardless of the method of payment elected, a claim should be sent to the carrier as soon as possible after the patient's expenses reach $50 so that future benefit payments for covered services may be made as claims are sent in.

Any arrangement concerning the initial $50 and the 20 percent co-insurance is a private matter between the physician and his patient.

Health Services Not Covered by Either Hospital Insurance or Medical Insurance

Under each kind of benefit described under hospital insurance, there is a list of items and services hospital insurance will not pay for. The medical insurance part of the book also has a list of items and services that medical insurance will not pay for. But there are some other items or services that are not covered under either part of Medicare. These are shown in the following list:

- Services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- Cosmetic surgery—*except when furnished in connection with prompt repair of accidental injury or for the improvement of the functioning of a malformed body member.*
- Services for which neither the patient nor another party on his behalf has a legal obligation to pay—*such as free chest X-ray.*
- Certain services payable under other Federal, State, or local government programs.
- Services furnished by immediate relatives or members of the patient's household.

The Blood Deductible Under Both Hospital Insurance and Medical Insurance

'67 Medicare cannot pay for the first 3 pints of whole blood (or units of packed red blood cells) the patient receives under either hospital or medical insurance.

- Hospital insurance cannot pay for the first 3 pints of blood the patient receives **in a benefit period.**
- Medical insurance cannot pay for the first 3 pints of blood the patient receives **in a calendar year.**

These are **separate** rules and they operate independently of each other. For example, if the patient receives blood under both hospital insurance and medical insurance, Medicare could not pay for the first 3 pints of blood under **either** program.

Some people are able to arrange for the replacement of these first 3 pints of blood—that way they don't have to pay for them. There are two ways this can be done. First, the patient may arrange for replacement from a friend or relative or he may be a member of a blood donor group that will replace these first 3 pints of blood for him. Second—*and this is often overlooked*—the patient's children (or son-in-law or daughter-in-law) may belong to a blood replacement plan that includes the patient as a beneficiary. In that case, the patient would be eligible for blood on the basis of *their* membership.

In almost all blood donor plans, blood replacement credit can be arranged anywhere in the United States. Patients should check with their children and children-in-law about this so they'll have the information handy if they ever need it.

REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

(See Instructions on Back—Type or Print Information)

Form Approved
Budget Bureau No.
72-R0730

PART I—PATIENT TO FILL IN ITEMS 1 THROUGH 6 ONLY

A

Copy from your HEALTH INSURANCE CARD *(See example on back)*

1 Name of patient

2 Health insurance claim number

☐ Male ☐ Female

3 Patient's street address

City, State, ZIP code

Telephone Number

4 Describe the illness or injury for which you received treatment *(Always fill in this item if your doctor does not complete Part II below)*

Was your illness or injury connected with your employment?

☐ Yes ☐ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information.

Insuring organization or State agency name and address

Policy or Medical Assistance Number

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below.

Signature of patient *(See instructions on reverse where patient is unable to sign)*

Date signed

SIGN HERE

PART II—PHYSICIAN OR SUPPLIER TO FILL IN 7 THROUGH 14

7 A. Date of each service	B. Place of service (*See Codes below)	C. Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D. Nature of illness or injury requiring services or supplies	E. Charges (If related to unusual circumstances explain in 7C)	Leave Blank
				$	

8 Name and address of physician or supplier *(Number and street, city, State, ZIP code)*

Telephone No.

Physician or supplier code

9 Total charges $

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill

☐ I accept assignment ☐ I do not accept assignment

13 Show name and address of facility where services were performed *(If other than home or office visits)*

14 Signature of physician or supplier *(A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)*

☐ MD ☐ DO ☐ DDS

Other degree _____

Date signed

*O—Doctor's Office
IL—Independent Laboratory
H—Patient's Home *(If portable X-ray services, identify the supplier)*
IH—Inpatient Hospital
ECF—Extended Care Facility
OH—Outpatient Hospital
OL—Other Locations
NH—Nursing Home

FORM SSA-1490 (4-68)

Department of Health, Education, and Welfare
Social Security Administration

HOW TO FILL OUT YOUR MEDICARE FORM

There are two ways that Medicare can help pay your doctor bills

One way is for Medicare to pay your doctor.—If you and your doctor agree, Medicare will pay him directly. This is the assignment method. You do not submit any claim; the doctor does. All you do is fill out Part I of this form and leave it with your doctor. Under this method the doctor agrees to accept the charge determination of the Medicare carrier as the full charge; you are responsible for the deductible and coinsurance. Please read Your Medicare Handbook to help you understand about the deductible and coinsurance. (Because Medicare has special payment arrangements with group practice prepayment plans, these plans handle all claims for covered services they furnish to their members.)

The other way is for Medicare to pay you.—Medicare can also pay you directly—before or after you have paid your doctor. If you submit the claim yourself, fill out Part I and ask your doctor to fill out Part II. If you have an itemized bill from him, you may submit it rather than have him complete Part II. (This form, with Part I completed by you, may be used to send in several itemized bills from different doctors and suppliers.) Bills should show who furnished the services, the patient's name and number, dates of services, where the services were furnished, a description of the services, and charges for each separate service. It is helpful if the diagnosis is also shown. Then mail itemized bills and this form to the address shown in the upper left-hand corner, Block A. If no address is shown there, use the address listed in Your Medicare Handbook—or get advice from your nearest social security district office.

SOME THINGS TO NOTE IN FILLING OUT PART I (Your doctor will fill out Part II).

1 & 2 Copy the name and number and indicate your sex exactly as shown on your health insurance card. Include the letters at the end of the number.

3 Enter your mailing address and telephone number, if any.

4 Describe your illness or injury. Be sure to check one of the two boxes.

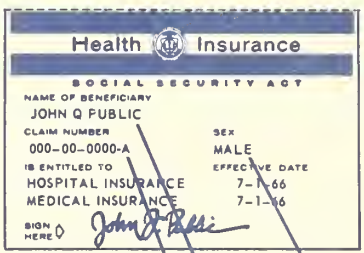
5 If you have other health insurance or expect a welfare agency to pay part of the expenses, complete item 5.

6 Be sure to sign your name. If you cannot write your name, sign by mark (X), and have a witness sign his name and enter his address on this line.

If the claim is filed for the patient by another person he should enter the patient's name and write "By", sign his own name and address in this space, show his relationship to the patient, and why the patient cannot sign. (If the patient has died the survivor should contact the nearest social security office for information on what to do.)

IMPORTANT NOTE.—This form may also be used by a supplier, or by you to claim reimbursement for charges by a supplier for services such as the use of an ambulance or medical appliances.

If the physician or supplier does not want Part II information released to the organization named in item 5, he should write "No further release" in item 7C following the description of services.


Health Insurance

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JOHN Q PUBLIC

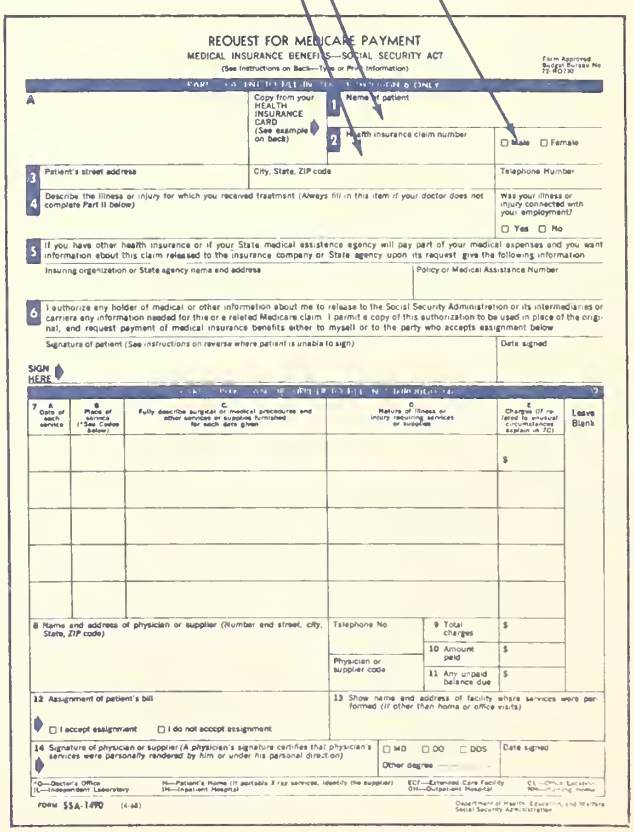
CLAIM NUMBER
000-00-0000-A

SEX
MALE

IS ENTITLED TO
HOSPITAL INSURANCE
MEDICAL INSURANCE

EFFECTIVE DATE
7-1-66
7-1-66

SIGN HERE
John Q Public


REQUEST FOR MEDICARE PAYMENT

MEDICAL INSURANCE BENEFITS—SOCIAL SECURITY ACT

(See instructions on Back—Type or Print Information)

Form Approved Budget Bureau No 72-R030

PART I—TO BE FILLED IN BY PATIENT OR PERSON ACTING ON HIS BEHALF ONLY

A

Copy from your HEALTH INSURANCE CARD (See example on back)

1 Name of patient

2 Health insurance claim number

☐ Male ☐ Female

3 Patient's street address

City, State, ZIP code

Telephone Number

4 Describe the illness or injury for which you received treatment (Always fill in this item if your doctor does not complete Part II below)

Was your illness or injury connected with your employment?

☐ Yes ☐ No

5 If you have other health insurance or if your State medical assistance agency will pay part of your medical expenses and you want information about this claim released to the insurance company or State agency upon its request, give the following information

Insuring organization or State agency name and address

Policy or Medical Assistance Number

6 I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment below

Signature of patient (See instructions on reverse where patient is unable to sign)

Date signed

SIGN HERE

PART II—TO BE FILLED IN BY PHYSICIAN OR SUPPLIER ONLY

7 A Date of each service	B Place of service (*See Codes below)	C Fully describe surgical or medical procedures and other services or supplies furnished for each date given	D Nature of illness or injury requiring services or supplies	E Charges (If related to physical circumstances explain on 7C)	Leave Blank
				$	

8 Name and address of physician or supplier (Number and street, city, State, ZIP code)

Telephone No

Physician or supplier code

9 Total charges $

10 Amount paid $

11 Any unpaid balance due $

12 Assignment of patient's bill

☐ I accept assignment ☐ I do not accept assignment

13 Show name and address of facility where services were performed (If other than home or office visits)

14 Signature of physician or supplier (A physician's signature certifies that physician's services were personally rendered by him or under his personal direction)

☐ MD ☐ DO ☐ DDS

Other degree

Date signed

*O—Doctor's Office IL—Independent Laboratory H—Patient's Home (If portable X-ray services, identify the supplier) IH—Inpatient Hospital ECF—Extended Care Facility OH—Outpatient Hospital CL—Clinic, Laboratory, Rehabilitation Agency, Public Health Agency, or Other Facility

FORM SSA-1490 (4-66)

Department of Health, Education, and Welfare Social Security Administration

Notes

MEDICARE ORGANIZATIONS AND PEOPLE TO CONTACT

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INTERMEDIARIES

SOCIAL SECURITY OFFICES

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Where to Find the 1967 Changes

To find where the 1967 changes are described on the page, look for this Symbol. '67

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Special Rules for Benefits in Psychiatric Hospitals	9
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Payment of Full Reasonable Charges for Laboratory and Radiology Services for Hospital Inpatients	18
All Hospital Outpatient Benefits Are Now Covered by Medical Insurance	19
Additional Outpatient Physical Therapy Services Are Covered Starting July 1, 1968	19
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Certain Diagnostic X-Ray Services Using Portable Equipment Are Covered	21
Purchase of Durable Medical Equipment Is Covered	21
Payment Can Be Made Under Medical Insurance for Certain Hospital Services	21
Medical Insurance Claims Can Be Made With A Non-Receipted Bill	23
Time Limits for Submitting Medical Insurance Claims	24
First 3 Pints of Blood Not Covered Under Medical Insurance	27
Packed Red Blood Cell Deductible	27

For further information about Medicare or for help in any social security matter, call, write, or visit your social security office.

U.S. DEPARTMENT OF HEALTH, EDUCATION, AND WELFARE ● SOCIAL SECURITY ADMINISTRATION

☆ U.S. GOVERNMENT PRINTING OFFICE : 1968 O—315-742